CS0020

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(FOR USE WHEN ENGAGING PLACEMENT AGENTS)

Check (✓) Facility:

☐ CHI St. Gabriel's Health ☐ CHI St. Alexius Health ☐ CHI St. Alexius Health – Garrison
☐ CHI St. Alexius Health – Turtle Lake ☐ CHI St. Joseph's Health ☐ Other: _____

I, _____, **(Print Name of Individual [i.e., patient])** hereby authorize above checked Facility(s) to use and disclose the protected health information as described below for the following patient:

Patient Name		Date of Birth
Street Address		Phone
City	State	Zip Code

I authorize the following person(s) or organization to receive the information:

Name		
Street Address		
City	State	Zip Code
Phone	Email Address	

Reason or purpose for the use and/or disclosure of the information:
To assist with coordinating post-hospitalization referrals to a variety of residential care facilities.

The following individually identifiable health information may be used and/or disclosed:

Demographics, physical and mental health assessments, medical diagnoses, treatment plans, results of diagnostic testing, medications, immunization status, lab results, physician notes, therapy notes, medical history.

Dates of episode to be released: From: _____ To: _____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Prohibition on Conditioning of Authorization: The health care provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

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Re-Disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire one year from the date signed unless the facility receives a Revocation as outlined below.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the Facility/Clinic/Entity specified on this release or completing the "Revocation of Authorization" form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the facility's Notice of Privacy Practices.

Signature of Patient or Guardian	Date
Print Name	

If you are the Personal Representative of the Patient:

Signature of Personal Representative
Authority or Relationship to Patient

----------FOR HOSPITAL/CLINIC USE ONLY----------

Please include copies of any documents that establish Personal Representation such as Power of Attorney document, Guardianship papers, Executor of Estate or Administrator of will documents.

You must provide patient with a copy of this signed form.

You must send the original signed form to Health Information Management for incorporation into the patient's medical record.